UNITED STATES DISTRICT COURT

for the

Middle District of Tennessee

_____ Division

03-20 1029

Case No. _____

(to be filled in by the Clerk's Office)

Mary Aiad Agaiby Harown

Plaintiff(s)

(Write the full name of each plaintiff who is filing this complaint. If the names of all the plaintiffs cannot fit in the space above, please write "see attached" in the space and attach an additional page with the full list of names.)

-v-

Amazon (wherehouse)

Defendant(s)

(Write the full name of each defendant who is being sued. If the names of all the defendants cannot fit in the space above, please write "see attached" in the space and attach an additional page with the full list of names.)

Jury Trial: *(check one)* ☐ Yes ☐ No

COMPLAINT FOR EMPLOYMENT DISCRIMINATION

I. The Parties to This Complaint

A. The Plaintiff(s)

Provide the information below for each plaintiff named in the complaint. Attach additional pages if needed.

Name	Mary Aiad Agaiby Harown
Street Address	654 Windell Wood Cir
City and County	Smyrna
State and Zip Code	TN 37167
Telephone Number	(615)892 3737
E-mail Address	Aymanhanna15@yahoo.com

B. The Defendant(s)

Provide the information below for each defendant named in the complaint, whether the defendant is an individual, a government agency, an organization, or a corporation. For an individual defendant, include the person's job or title *(if known)*. Attach additional pages if needed.

Defendant No. 1

Name: Amazon
Job or Title *(if known)*:
Street Address: 2020 Joe B Jackson pkwy
City and County: Murfreesboro
State and Zip Code: TN
Telephone Number: 800) 9284566
E-mail Address *(if known)*:

Defendant No. 2

Name:
Job or Title *(if known)*:
Street Address:
City and County:
State and Zip Code:
Telephone Number:
E-mail Address *(if known)*:

Defendant No. 3

Name:
Job or Title *(if known)*:
Street Address:
City and County:
State and Zip Code:
Telephone Number:
E-mail Address *(if known)*:

Defendant No. 4

Name:
Job or Title *(if known)*:
Street Address:
City and County:
State and Zip Code:
Telephone Number:
E-mail Address *(if known)*:

C. Place of Employment

The address at which I sought employment or was employed by the defendant(s) is

Name	Amazon
Street Address	2020 Joe B Jackson pkwy
City and County	MURfreesboro
State and Zip Code	TN
Telephone Number	(800) 928-4566

II. Basis for Jurisdiction

This action is brought for discrimination in employment pursuant to *(check all that apply)*:

☐ Title VII of the Civil Rights Act of 1964, as codified, 42 U.S.C. §§ 2000e to 2000e-17 (race, color, gender, religion, national origin).

(Note: In order to bring suit in federal district court under Title VII, you must first obtain a Notice of Right to Sue letter from the Equal Employment Opportunity Commission.)

☐ Age Discrimination in Employment Act of 1967, as codified, 29 U.S.C. §§ 621 to 634.

(Note: In order to bring suit in federal district court under the Age Discrimination in Employment Act, you must first file a charge with the Equal Employment Opportunity Commission.)

☒ Americans with Disabilities Act of 1990, as codified, 42 U.S.C. §§ 12112 to 12117.

(Note: In order to bring suit in federal district court under the Americans with Disabilities Act, you must first obtain a Notice of Right to Sue letter from the Equal Employment Opportunity Commission.)

☐ Other federal law *(specify the federal law)*:

☐ Relevant state law *(specify, if known)*:

☐ Relevant city or county law *(specify, if known)*:

III. Statement of Claim

Write a short and plain statement of the claim. Do not make legal arguments. State as briefly as possible the facts showing that each plaintiff is entitled to the damages or other relief sought. State how each defendant was involved and what each defendant did that caused the plaintiff harm or violated the plaintiff's rights, including the dates and places of that involvement or conduct. If more than one claim is asserted, number each claim and write a short and plain statement of each claim in a separate paragraph. Attach additional pages if needed.

A. The discriminatory conduct of which I complain in this action includes *(check all that apply)*:

- ☐ Failure to hire me.
- ☒ Termination of my employment.
- ☐ Failure to promote me.
- ☒ Failure to accommodate my disability.
- ☐ Unequal terms and conditions of my employment.
- ☐ Retaliation.
- ☐ Other acts *(specify)*: _____

(Note: Only those grounds raised in the charge filed with the Equal Employment Opportunity Commission can be considered by the federal district court under the federal employment discrimination statutes.)

B. It is my best recollection that the alleged discriminatory acts occurred on date(s)

2/22/2020

C. I believe that defendant(s) *(check one)*:

- ☐ is/are still committing these acts against me.
- ☒ is/are not still committing these acts against me.

D. Defendant(s) discriminated against me based on my *(check all that apply and explain)*:

- ☐ race _____
- ☐ color _____
- ☐ gender/sex _____
- ☐ religion _____
- ☐ national origin _____
- ☐ age *(year of birth)* _____ *(only when asserting a claim of age discrimination.)*
- ☒ disability or perceived disability *(specify disability)*

I had diable lumbar fissure

E. The facts of my case are as follows. Attach additional pages if needed.

(Note: As additional support for the facts of your claim, you may attach to this complaint a copy of your charge filed with the Equal Employment Opportunity Commission, or the charge filed with the relevant state or city human rights division.)

IV. Exhaustion of Federal Administrative Remedies

A. It is my best recollection that I filed a charge with the Equal Employment Opportunity Commission or my Equal Employment Opportunity counselor regarding the defendant's alleged discriminatory conduct on *(date)*

04/2020

B. The Equal Employment Opportunity Commission *(check one)*:

- ☐ has not issued a Notice of Right to Sue letter.
- ☒ issued a Notice of Right to Sue letter, which I received on *(date)* 09/22/2020

(Note: Attach a copy of the Notice of Right to Sue letter from the Equal Employment Opportunity Commission to this complaint.)

C. Only litigants alleging age discrimination must answer this question.

Since filing my charge of age discrimination with the Equal Employment Opportunity Commission regarding the defendant's alleged discriminatory conduct *(check one)*:

- ☐ 60 days or more have elapsed.
- ☐ less than 60 days have elapsed.

V. Relief

State briefly and precisely what damages or other relief the plaintiff asks the court to order. Do not make legal arguments. Include any basis for claiming that the wrongs alleged are continuing at the present time. Include the amounts of any actual damages claimed for the acts alleged and the basis for these amounts. Include any punitive or exemplary damages claimed, the amounts, and the reasons you claim you are entitled to actual or punitive money damages.

VI. Certification and Closing

Under Federal Rule of Civil Procedure 11, by signing below, I certify to the best of my knowledge, information, and belief that this complaint: (1) is not being presented for an improper purpose, such as to harass, cause unnecessary delay, or needlessly increase the cost of litigation; (2) is supported by existing law or by a nonfrivolous argument for extending, modifying, or reversing existing law; (3) the factual contentions have evidentiary support or, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further investigation or discovery; and (4) the complaint otherwise complies with the requirements of Rule 11.

A. For Parties Without an Attorney

I agree to provide the Clerk's Office with any changes to my address where case–related papers may be served. I understand that my failure to keep a current address on file with the Clerk's Office may result in the dismissal of my case.

Date of signing: 10/27/2020

Signature of Plaintiff Mary Harown

Printed Name of Plaintiff Mary Harown

B. For Attorneys

Date of signing: _____

Signature of Attorney _____

Printed Name of Attorney _____

Bar Number _____

Name of Law Firm _____

Street Address _____

State and Zip Code _____

Telephone Number _____

E-mail Address _____

Long term disability

Mary Harown

621

Please fax the completed form to:
Fax Number: 888-411-8613
The Hartford
P.O.Box 14301
Lexington, KY 40512-4301
Email: APSupload@thehartford.com

THE HARTFORD

ATTENDING PHYSICIAN'S STATEMENT - PROGRESS REPORT

To be completed by the Employee

Patient Name: Mary Harown	Date of Birth: 8-27-77	Insured ID Number:

Patient Address: (Street, City, State & Zip Code)
654 windellwood cir smyrna TN 37167

To be completed by the Provider - Use current information from your patient's most recent office visit or examination to complete this form. (The patient is responsible for the completion of this form without expense to the Company.)

Medical Conditions Impacting Activity

Primary condition: post-laminectomy syntrome — ICD-9 Code: ☐ ICD-10 Code: ☑ M96.18

Secondary condition(s): radiculopathy, lumbar — ICD-9 Code: ☐ ICD-10 Code(s): ☑ M54.16

Subjective symptoms: low back pain, lower extremity pain

Objective Physical Findings (Please include office notes for date(s): ____ to ____
please most current clinic note 1-9-20

Pertinent Test Results (list all results or attach test results):
Test: MRI lumbar +/- contrast Date: 12/23/19 Results: prior surgery L4-5, multi-level degenerate spondylosis
Test: ____ Date: ____ Results: ____

Condition(s) Specific Medications, Dosage and Frequency:
1) Norco 7.5/325 mg 1 pobid 2) pregabalin 50mg qhs 3) mobic 15mg daily

TREATMENT PLAN

Current Treatment Plan: medication, bracing, injections, therapy @ home, chiropractor

What is the Frequency / Duration of Treatment? monthly Dates of Treatment: 2017 - present

First Office Visit for this condition: 8'17 Last Office Visit: 1'20 Next Scheduled Office Visit: 2'20

Has Surgery been performed since last report: ☑ Yes ☐ No If "Yes," on what Date(s): Nov. 2018

Procedure(s): lumbar laminectomy L4-5 CPT Code(s): ____

Was patient hospitalized since last report? ☐ Yes ☑ No If "Yes," Hospital name and Phone Number: ____

Admission date: ____ Discharge date: ____

Has patient been referred to other physicians? ☐ Yes ☑ No If "Yes," Date of Referral(s): ____

Other Physician Name ____ Phone Number: ( ) ____ Specialty: ____

Other Physician Name ____ Phone Number: ( ) ____ Specialty: ____

Claim ID: 16155705

000054 5/5

Patient Name: Date of Birth: Insured ID Number:

Please complete this section to the best of your ability. Generalized comments such as "unable to work" may delay your patient's disability benefits.

Based on your most recent medical findings and opinion, address the full range of restrictions/limitations, noting that we will conclude there are no restrictions on function unless specified below.

Restrictions/Limitations based on office visit dated: 1-9-20 Expected Return to Work date: N/A

In an 8 hour period the patient is able to: (select either continuous or intermittent)

	Continuously with standard breaks		Intermittently with standard breaks	If intermittent circle time for each section below: Hours at one time	Total hours/8 hours
Sit	☐	or	☒	(1) 2 3 4 5 6 7 8	1 2 3 (4) 5 6 7 8
Stand	☐	or	☒	(1) 2 3 4 5 6 7 8	1 2 3 (4) 5 6 7 8
Walk	☐	or	☒	(1) 2 3 4 5 6 7 8	1 2 3 (4) 5 6 7 8

Provide medical findings/rationale for your opinion if patient is unable to continuously sit, stand or walk:

Activity Ability (with normal breaks)	Never 0 hours	Occasionally up to 2.5 hours	Frequently 2.5 to 5.5 hours	Constantly 5.5 to 8 hours	Please indicate diagnosis, symptoms, exam findings, and/or imaging that supports the restrictions/limitations
Bend at waist	☒	☐	☐	☐	see clinic Note / MRI
Kneel/crouch	☒	☐	☐	☐	
Climb	☒	☐	☐	☐	
Balance	☒	☐	☐	☐	
Drive	☐	☒	☐	☐	
Lift - Indicate weight in pounds		5 lbs.	5 lbs.	5 lbs.	
Other Restrictions (if any)_____	☐	☐	☐	☐	
Hand Dominance: ☒ Right ☐ Left					
Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral					
Fine manipulation (fingering, keyboard)	☐	☐	☐	☒	
Gross manipulation (grip/grasp, handle)	☐	☐	☐	☒	
Reach (extend arms) above shoulder	☐	☒	☐	☐	
Reach (extend arms) below shoulder at desk or workbench level	☐	☒	☐	☐	

Please attach copies of imaging results/tests

Expected duration of any restriction(s) or limitation(s) listed above: _____

Current Status (Please check one): ☐ Recovered ☐ Improved ☒ Unchanged ☐ Retrogressed

Additional Comments (If Necessary): N/A

Does the patient have a psychiatric / cognitive impairment? ☐ Yes ☒ No If "Yes," please describe the extent of the impairment and its etiology:

In your opinion is the patient competent to endorse checks and direct the use of the proceeds? ☒ Yes ☐ No

Provider's Name: (please print or type) Edward Orsigny | EIN Number: | License Number:

Telephone Number: (615) 866-9040 | Fax Number: (615) 750-5756 | Degree: MD | Specialty: pain management

Street Address (Street, City, State & Zip Code): 3220 perimeter hill drive Antioch, TN 37013

Office Contact and Telephone Number:

Provider's Signature: _____ Date signed: 1/16/20

Claim ID: 16153705

What I was doing in Amazon:-
They were filling up the carts and what I had to do was getting the items off the cart and put it on the table in front of the computer so we can ship it in the big trucks.

What was wrong with working in Amazon
I was supposed to work fast so I can make my rate and keep my job and I had to do 170 an hour and they didn't care about me all they cared about was getting the job done. Sometimes the items were big and weighed a lot. I really needed the money so I had to work hard and make my numbers (rate) so I don't get fired and to support my family.

After working in Amazon I started feeling back pain and I found out later on that there was pressure on my back nerves and of course that wasn't easy to deal with after going to the doctor he told me to reduce my work hours from 40 hours a week to 24 hours. I even couldn't work the 24 hours because of the pain it was miserable. Then I got a note from my doctor for a medical leave to do a surgery in my back hoping I would get better. Unfortunately I didn't get better after the surgery and the pain was the same. I couldn't do anything I was just laying on the bed and I couldn't even get up, even in my sleep I was having pain. Nothing was helping the pain I was trying to keep my self distracted by standing up for little bit or sitting down but nothing was changing. My doctor gave me pain medication and Anesthetic and he told me to take them four times a day. I got depressed because of the pain and I was feeling really bad after they fired me from Amazon I even thought of suiciding two times.

Premier Radiology SMYRNA | Saint Thomas Health

PREMIER RADIOLOGY SMYRNA
741 President Place Suite 100
Smyrna, TN 37167
Phone #: (615)220-0674
Fax: (615)355-4348

Name:	MARY HAROWN	Exam Date:	12/23/2019 11:02 AM
Patient ID:	1001438652	Exam Name:	MR Lumbar Spine wo/w Contrast | 72158
Age:	43Y 1M	Referrer:	EDWARD OSUIGWE, PA
Secondary ID:		2nd Referrer:	
DOB:	8/27/1977		
Acc #:	6547443		

PROCEDURE: MRI LUMBAR SPINE WITHOUT AND WITH CONTRAST

TECHNIQUE: Magnetic resonance imaging of the lumbar spine was performed using standard pulse sequences before and after the IV injection of paramagnetic contrast. CPT 72158

HISTORY: . Lumbago M96.1 Postlaminectomy syndrome, not elsewhere classified

COMPARISONS: 2/21/2019.

FINDINGS:
Changes of prior RIGHT hemilaminotomy or hemilaminectomy L4-L5. No significant change in alignment including mild 2 mm anterolisthesis L4 on L5. No other significant listhesis. Lumbar vertebral body heights are maintained. No suspicious marrow lesion. The spinal cord terminates normally at the T12 level, with normal signal in the conus. No pathologic enhancement. The paraspinal soft tissues are unremarkable.

T12-L1: No significant abnormality.

L1-2: No significant abnormality.

L2-3: No significant abnormality.

L3-4: Mild broad-based annular disc bulge and mild facet arthropathy produce minimal bilateral foraminal stenosis. No significant central canal stenosis.

L4-5: Prior RIGHT hemilaminotomy or hemilaminectomy. Minimal broad-based annular disc bulge and facet arthropathy produce mild bilateral foraminal stenosis and mild LEFT lateral recess stenosis. No significant central canal stenosis.

L5-S1: No significant abnormality.

IMPRESSION:
1. Prior surgical changes L4-L5.
2. Mild multilevel degenerative spondylosis lower lumbar spine.

ws:PSMTNRDWINX2E9E

Electronically Signed by: Eric Green M.D.
Electronically Signed on: 12/23/2019 12:05 PM

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